MILWAUKEE COUNTY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Housing Division

PROGRAM REQUIRMENTS/DESCRIPTIONS

YEAR 2016
REQUEST FOR PROPOSAL
PURCHASE OF SERVICE GUIDELINES

Issued July 20, 2015
Proposal due 4:00 PM CDT, September 8, 2015

Ver. 07202015

HOUSING DIVISION

PROGRAM REQUIRMENTS/DESCRIPTIONS

PART 1

PROGRAM PROPOSAL REQUIREMENTS

REQUIRED SUBMITTALS - PROGRAM PROPOSAL

Technical Requirements		Proposal	
Item #	Item Description	Check each Item Included	Page # of Proposal
Part 3 –PROGRAM PROPOSAL			
20	Program Organizational Chart		
21	Program Mission Statement		
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25c	Experience Assessment For Agency		
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27	Accessibility		
28	Staffing Plan		
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30	Current Direct Service Provider/Indirect Staff Roster		
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Agency attests that all items and documents checked are complete and included in the proposal packet.

Authorized Signature: _____ Date: _____

Printed Name: _____

Title: _____

Agency: _____

See also the *2016 Technical Requirements* booklet for additional forms and instructions.

Program Descriptions begin on page 2-HD-1

Performance-Based Contracts

Over the next few years, the programs up for competitive proposals for 2016 and later will be converted to **performance-based contracts**. The timeframe over which these contracts will be phased in will depend upon the program. Each specific program description will indicate whether it is performance-based and the tentative timeframe over which the performance measures will be implemented. In some cases, 2016 will be used to gather data and obtain a baseline. In other cases, baseline information is already available to the program and the performance incentives will begin to be paid in 2016.

As with non-performance-based contracts, contracts with a performance component will have a base amount that can be earned by invoicing monthly for the quantity of units provided or expenses booked in performing services under the program. However, over and above the base amount of the contract, agencies will have the opportunity to receive additional payments quarterly, or at intervals as determined by the program, by showing that performance goals were met during the associated performance period. Performance goals will be specified for each affected program description in this document. In many cases, these programs will also have additional performance goals that contractors will be expected to meet, but only a portion of those goals have been tied to performance-based payments.

When completing your budget for a performance-based program, budget for the total amount of the contract, the base allocation plus the performance incentive, if any.

Program descriptions may set minimum performance targets. For some programs, the level of performance proposed by respondents over and above minimum targets may, in part, serve as a basis for scoring proposals. In some cases, the required level of achievement for each indicator in order to earn the performance incentive may be arrived at during contract negotiations.

Successful proposers will receive instructions on invoicing for the base amount as well as for the performance-based payments prior to the start of the new contract.

This *PROGRAM REQUIRMENTS/DESCRIPTIONS* document is made up of Program Requirements, Forms and Procedures (Part 1), and Program Descriptions (Part 2). Make sure you read and understand the requirements of the program description in Part 2 before beginning to write your program proposal under Part 1.

PROGRAM PROPOSAL: COMPLETE FOR EACH PROGRAM

A separate PROGRAM PROPOSAL must be completed **for each program** for which an agency is requesting DHHS funding. Agencies are required to submit a separate program proposal section for each program, not for each site. If an agency offers a program at more than one site, Items 26 and 27 must be submitted **for each site**. One original and five copies of each program proposal must be submitted in ordered to be considered for programs up for competitive proposals.

PROGRAM ORGANIZATIONAL CHART *ITEM # 20*

Provide an organizational chart which shows, in detail, position titles and reporting relationships within the specific program being proposed. Include all positions for which funding is being requested.

YEAR 2016 MISSION STATEMENT *ITEM # 21*

Submit your agency's Mission Statement related to the program you are applying for. Explain how it aligns with the Division or Program's stated mission, values or goals.

(Item 21 comprises the points scored under Mission)

AGENCY LICENSES AND CERTIFICATIONS *ITEM # 22*

Submit a copy of each agency license or certificate required to provide the service for which you are requesting funds and copies of any notices of noncompliance or restrictions.

CULTURAL COMPETENCE *ITEM # 23*

Cultural Competence *- A set of congruent behaviors, attitudes, practices and policies formed within a system, within an agency, and among professionals to enable the system, agency and professionals to work respectfully, effectively and responsibly in diverse situations. Essential elements of cultural competence include valuing diversity, understanding the dynamics of difference, institutionalizing cultural knowledge, and adapting to and encouraging organizational diversity.*

Cultural Humility *- Cultural Humility recognizes variation within members of a group which may otherwise be similar in terms of race, gender, ethnicity, or other characteristic. The emphasis in Cultural Humility is not on specific knowledge of any given cultural orientation, but rather on an approach which demonstrates a respectful attitude toward diverse points of view, recognizing that groups of individuals cannot be reduced to a set of discrete traits. This approach specifically avoids making broad assumptions about groups based on defined traits or behaviors; instead, it focuses on recognizing and integrating the unique perspective each client brings to the service delivery experience.*

Describe your proposed strategy for developing and maintaining Cultural Competence. Apart from having a culturally diverse board and or staff, please provide specific examples of existing and/or proposed policies, procedures, and other practices promoting Cultural Competence. A defining characteristic of Cultural Humility is client centered care. Proposers should describe their client centered approach specifically in terms of how it incorporates Cultural Humility.

(Item 23 partially comprises the points scored under Cultural Diversity and Cultural Competence)

EMERGENCY MANAGEMENT PLAN

ITEM # 24

In order for Agencies under contract with DHHS to be prepared for a natural or man-made disaster, or any other internal or external hazard that threatens clients, staff, and/or visitor life and safety, and in order to comply with federal and state requirements, Agencies shall have a written Emergency Management Plan (EMP). All employees shall be oriented to the plan and trained to perform assigned tasks. **Submit a summary of your Emergency Management Plan (no more than 6 pages) that identifies the steps Proposer has taken or will be taking to prepare for an emergency and address, at a minimum, the following areas and issues:**

1. Agency's order of succession and emergency communications plan, including who at the facility/organization will be in authority to make the decision to execute the plan to evacuate or shelter in place and what will be the chain of command;
2. Develop a continuity of operations business plan using an all-hazards approach (e.g., floods, tornadoes, blizzards, fire, electrical blackout, bioterrorism, pandemic influenza or other natural or man-made disasters) that could potentially affect current operations or site directly and indirectly within a particular area or location;
3. Identify services deemed "essential", and any other services that will remain operational during an emergency (**Note, Agencies who offer case management, residential, or personal care for individuals with medical, cognitive, emotional or mental health needs, or to individuals with physical or developmental disabilities are deemed to be providers of essential services**);
4. Identify and communicate procedures for orderly evacuation or other response approved by local emergency management agency during a fire emergency;
5. Plan a response to serious illness, including pandemic, or accidents;
6. Prepare for and respond to severe weather including tornado and flooding;
7. Plan a route to dry land when a facility or site is located in a flood plain;
8. For residential facilities, identify the location of an Alternate Care Site for Residents/Clients (Note, this should include a minimum of two alternate facilities, with the second being at least 50 miles from the current facility);
9. Identify a means, other than public transportation, of transporting residents to the Alternate Care location (Note, for Alternate Care Sites and transportation, a surge capability assessment and Memorandum of Understanding (MOU) with Alternate Care Site and alternative transportation provider should be included in the development of the emergency plan);
10. Identify the role(s) of staff during an emergency, including critical personnel, key functions and staffing schedules (**Note, in the case of Personal Care Workers, staff should be prepared to accompany the Client to the Alternate Care Site, or local emergency management identified Emergency Shelter**). Provide a description of your agency's proposed strategy for handling

fluctuations in staffing needs. Examples may include, but are not limited to: referral networks, flexible staffing, on-call staff, or "pool" workers, and other strategies to expand or reduce physical or staff capacity due to crisis, variations in client volume, or other staffing emergencies;

11. Identify how meals will be provided to Residents/Clients at an Alternate Care Site. In addition, a surge capacity assessment should include whether the Agency, as part of its emergency planning, anticipates the need to make housing and sustenance provisions for the staff and/or the family of staff;
12. Identify how Agencies who offer case management, residential care, or personal care for individuals with substantial cognitive, medical, or physical needs shall assist Clients to individually prepare for an emergency and obtain essential services during an emergency, including developing a Care Plan that includes an emergency plan on an individual level.
13. Ensure that current assessment and treatment plan for each Resident/Client with specific information about the characteristics and needs of the individuals for whom care is provided is available in an emergency and accompanies the Resident/Client to the Alternate Care Site. This should include: Resident identification, diagnosis, acuity level, current drugs/prescriptions, special medical equipment, diet regimens and name and contact of next of Kin/responsible person/POA.
14. Identify staff responsible for ensuring availability of prescriptions/medical equipment and Client information at Alternate Care Site;
15. Communicate and Collaborate with local emergency management agencies to ensure the development of an effective emergency plan (typically the fire chief, or his/her designee); and
16. Collaborate with Suppliers and Personal Services Providers.

Describe, in detail, formal and informal agreements (such as Memoranda of Agreement) which support elements of your plan, as well as any specific examples of tests, drills, or actual implementation of any parts of your plan. Agencies shall have agreements or MOUs with other agencies or operators of Alternate Care Sites and assess the availability of volunteer staff for such emergencies.

Proposers can find resources for EMPs including sample plans, Mutual Aid Agreement and templates at the following website:

http://www.dhs.wisconsin.gov/rl_dsl/emergency-preparedness/emerg-prep-hva.htm

If Proposer serves persons with special needs receiving in-home care, or care in a supportive apartment, it should have the Client, the caregiver or someone upon whom the Client relies for personal assistance or safety complete the below referenced "DISASTER PREPAREDNESS CHECKLIST FOR INDIVIDUALS WITH SPECIAL NEEDS".

http://www.dhs.wisconsin.gov/preparedness/resources.htm

(Item 24 partially comprises the points scored under Administrative Ability)

PROGRAM LOGIC MODEL AND EVALUATION REPORT

(To be included In Initial Submission of ALL Proposals except for the Birth-3 Program) *ITEM # 25a*

Use single words or short phrases to describe the following:

Inputs: List the physical, financial, and human resources dedicated to the program.

Processes/Program Activities: List the services to be delivered, **to include any "Required Program Components" as described in the Program Description found in this document**.

Outputs: List the volume of processes/program activities to be delivered, **to include any "Expected Outputs" listed in Program Description.**

Expected Outcomes: List the intended benefit(s) for participants during or after their involvement with a program, **to include all "Expected Outcomes" listed in the Program description**, as well as any additional outcomes already established for the program. If no "Expected Outcomes" are listed in the Program Description, Proposer shall identify their own expected outcomes for the program. Proposer identified expected outcomes must reflect increases, decreases, or maintenance of knowledge, skills, behaviors, condition, and/or status.

Indicators List the measurable approximations of the outcomes you are attempting to achieve, **to include any required "Indicators" listed in the Program Description.** Indicators are the observable or measurable characteristics which indicate whether an outcome has been met, which shall be expressed by number and/or percentage.

For more examples of Inputs, Processes, Outputs, and Outcomes, see DHHS Outcomes Presentation, March 16, 2006, at: http://county.milwaukee.gov/ContractMgt15483.htm (Look under "Reference Documents")

Projected Level of Achievement-Using column F of your Program Logic Model (Item 29a), identify the number and percentage of participants you project will achieve each "Expected Outcome" for each program proposed.

Describe methods of data collection proposed. Describe how consumers and community members are integrated into the process of evaluating the program, as appropriate, e.g., through satisfaction surveys, board and committee membership, public forums, etc. Include copies of any instruments used to collect feedback from consumers or the community. Give a specific example of how the results of this feedback have been used.

PROGRAM LOGIC MODEL and ANNUAL EVALUATION REPORT *(Sample)* *ITEM # 25a*

A	B	C	C1	D	E	F	G	H
Inputs	**Processes/Program Activities**	**Outputs**	**For evaluation report** **Actual level of achievement**	**Expected Outcomes**	**Indicators**	**Projected level of achievement**	**For evaluation report** **Actual level of achievement**	**Description of changes**
Staff *Clients* *Community sites (list major ones)* *Community living curriculum* *Transportation (vans)*	*Staff establish sites for community activities.* *Staff and clients identify community interests.* *Staff arrange/coordinate transportation to/from community activities.* *Staff facilitate community activities.* *Staff conduct pre and post activity workshops to teach and support clients' involvement in community life*	*32 unduplicated clients will participate in 500 community living experiences.*		*Outcome 1:Clientsincrease awareness of community resources.*	*Number and percent of clients who demonstrate an increase in awareness of community resources, as measured by pre and post test scores*	*24 (75%) of clients will achieve the outcome*		
				Outcome 2: Clients increase utilization of public and private services in their community.	*Number and percent of clients who demonstrate an increase in utilization of public and private services in their community*	*24 (75%) of clients will achieve the outcome*		
				Outcome 3: Clients generalize acquired skills to other home and community living situations	*Number and percent of clients who generalize acquired skills to other home and community living situations*	*24 (75%) of clients will achieve the outcome*		

example

PROGRAM LOGIC MODELand ANNUAL EVALUATION REPORT

ITEM # 25a

A	B	C	C1	D	E	F	G	H
Inputs	**Processes/Program Activities**	**Outputs**	**For evaluation report**	**Expected Outcomes**	**Indicators**	**Projected level of achievement**	**For evaluation report**	
			Actual level of achievement				**Actual level of achievement**	**Description of changes**

PROGRAM NARRATIVE *ITEM # 25b*

Identify the name and number of the program for which you are requesting funding as it is identified in the Program Description.

Provide a narrative to adequately describe the program you are proposing. The Program Description Narrative MUST correspond with and derive from Item 25a, Program Logic Model.

Refer to the Program Description for all the required program components for the program you are proposing. In particular, each proposed program must include:

- All Required Program Components
- Required Documentation
- Expected Outputs
- Expected Outcomes
- Indicators

If no "Expected Outcomes" are listed in the Program Requirements, Proposer shall identify their own expected outcomes for the program. Proposer identified expected outcomes must reflect increases, decreases, or maintenance of the service recipients' knowledge, skills, behaviors, condition, or status. Where indicated, programs must utilize Indicators as they appear in the Program Requirements, OR Proposer shall propose a minimum of one indicator for each "Expected Outcome".

In your narrative, describe the agency's ability to provide this program, and the agency's experience serving the targeted populations. Include any existing agency programs utilizing a similar service delivery system and the number of years the program has been in operation. Discuss past service experience with similar contracts. Specifically address recent and current experience in terms of program volume, target population, dollar amount of contract, and service mix (i.e., types of services provided).

(Items 25a and b partially comprise the points scored under Service Plan and Delivery)

(Items 25b and 25c & 25d (as applicable) partially comprise the points scored under Previous Experience)

EXPERIENCE ASSESSMENT FOR NEW PROPOSER AGENCY *ITEM # 25c*

For agencies with some history of funding, but without a current DHHS contract. **This document shall be completed by a prior funder**, and is subject to verification**.**

If unable to get an Experience Assessment from a prior funder, proposer may submit alternate documentation to verify agency experience. Examples of alternate documentation include, but are not limited to: grant agreements, grant proposals, correspondence, contracts, evaluation reports, or annual reports. Please submit this information attached to form 25c. Also please provide contact information of the prior funder, i.e. contact person, title, phone number, and email address.

Performance Assessment for (Agency)_____

From (Funding Source)_____

Please provide the following information relating to Agency's history with Funding Source.

1. Name of Program_____

2. When and for how long did Funding Source fund this program?_____

   _____

3. Program volume: How many people did this program serve?_____

4. Target Population: What was the primary target population for this program?_____

   _____

5. What was the dollar amount provided by Funding Source?_____/year

6. What services were provided through this program?_____

   _____

   _____

7. Was this program funded through a federal, state or local funding stream under a cost reimbursement framework? (Y/N)_____

8. If no longer funding this program, why not?_____

_____

9. What level of program performance was achieved? Please calibrate your ratings according to the following scale:
   - 0 Does/did not meet expectations
   - 1 Meets/met very little of what is/was expected
   - 2 Meets/met fewer than half of expectations
   - 3 Meets/met more than half of expectations
   - 4 Meets/met all expectations
   - 5 Exceeds/exceeded all expectations

Please evaluate the following performance areas circling the number corresponding to the rating scale on previous page:

Appropriate use of budget
0 1 2 3 4 5 NA

Comments:_____

_____

Achievement of established outcomes
0 1 2 3 4 5 NA

Comments:_____

_____

Timely submission of program reports
0 1 2 3 4 5 NA

Comments:_____

_____

Accurate submission of program reports
0 1 2 3 4 5 NA

Comments:_____

_____

Signed,

_____

Name (print)_____

Title _____

Phone _____

Email _____

(*Items 25c, 25d, or 25e as applicable, partially comprise the points scored under Administrative Ability*

Item 25c or 25d, as applicable, comprises the points scored under Outcomes and Quality Assurance)

EXPERIENCE ASSESSMENT FOR NEW PROPOSER *ITEM #25d*
ORGANIZATIONAL LEADERSHIP

For new agencies, or for agencies without a contracting history of any kind, complete and submit this form. A separate form should be submitted for the *head of the organization, senior fiscal and program staff*. **This document shall be completed by a prior funder or by a prior employer**, and is subject to verification**.**

A separate form should be submitted for the *head of the organization and senior fiscal and program staff*. Please have a prior fundor or a prior employer complete the form(s).

If unable to get an Experience Assessment from a prior fundor, proposer may submit alternate documentation to verify organizational leadership. Examples of alternate documentation include, but are not limited to: current or previous position/job description, prior agency's mission statement, W2 form, or annual report. Please submit this information attached to form 25d. Also please provide contact information of the prior funder, i.e. contact person, title, phone number, and email address.

Performance assessment for (Individual):_____

From (Agency)_____

Please provide the following information relating to Individual's history with Agency.

1. Individual's title_____

   _____

2. When and for how long did Individual work for Agency?_____

   _____

3. Program volume: How many people were served by this program?_____

   What was Individual's role in program administration?

   _____Direct _____Indirect (supervision) _____Limited or none

4. Target Population: What was the primary target population for this program?_____

   _____

5. What was the dollar amount provided by Funding Source?_____/year

   What was Individual's role in fiscal management of the program?

   _____Direct _____Indirect (supervision) _____Limited or none

6. What services were provided through this program?_____

   _____

7. If no longer funding this program, why not?_____

   _____

8. What level of program performance was achieved? Please calibrate your ratings according to the following scale:

    0 Does/did not meet expectations
    1 Meets/met very little of what is/was expected
    2 Meets/met fewer than half of expectations
    3 Meets/met more than half of expectations
    4 Meets/met all expectations
    5 Exceeds/exceeded all expectations

Please evaluate the following performance areas circling the number corresponding to the rating scale on previous page:

Appropriate use of budget
0 1 2 3 4 5 NA

Comments:_____

_____

Achievement of established outcomes
0 1 2 3 4 5 NA

Comments:_____

_____

Timely submission of program reports
0 1 2 3 4 5 NA

Comments:_____

_____

Accurate submission of program reports
0 1 2 3 4 5 NA

Comments:_____

_____

Signed,_____

Name (print)_____

Title _____

Phone_____

Email _____

Program Evaluation: Agencies **currently under contract to the DHHS** in 2015 must include a copy of the most recent annual or semi-annual program evaluation report for the program currently provided, or, if several programs are being provided, for the program that is the most similar to the service being applied for in this proposal.

2016 PROVIDER SERVICE SITE INFORMATION *ITEM #26*

Provide a separate sheet for each site location where services are provided.

Agency Name:	Site Name:
Site Address:	City/State/Zip:
Site Contact Person:	Title:
Phone:	Email:
Fax:	

Describe differences in programs or services available at this site:

Total number of unduplicated consumers you are presently able to serve at any one time: _____

Total number of unduplicated consumers you are currently serving: _____

Please check if your agency provides the following at this site:
____Programs for men ____Programs for women ____Programs for men & women
____Services for pregnant women
____Services for families with children ____Childcare provided
____Services for Persons Involved in the Criminal Justice System
____Services for the Developmentally Disabled
____Services for the Physically Disabled
____Services for persons with co-occurring mental health and substance use disorders
____Wheelchair accessible

Hours of operation: ____for specific program ____for all programs at this site
_____Monday:
_____Tuesday:
_____Wednesday:
_____Thursday:
_____Friday:
_____Saturday:
_____Sunday:
_____Emergency contact available 24 hours_____Emergency number_____

_____ Agency owns this Service Site

_____ Agency leases this Service Site:

Expiration date of Lease: _____
(lease must extend through the end of the contract year, at minimum)

Item 26 Service Site Certification:

I certify that the **PROVIDER SERVICE SITE INFORMATION** is correct as of the date of proposal submission.

Signed,_____

Name (print)_____

Title _____

Phone _____

Email _____

PROGRAM ACCESSIBILITY

ITEM # 27

What is your agency's plan to serve clients:

- With physical disabilities

- With developmental disabilities

- With hearing impairment

- With visual impairment

- Who are non- English speaking or have limited English proficiency

- Who require personal care assistance

List any other services enhancing program access, e.g. agency located near public transportation, etc.

STAFFING PLAN

ITEM # 28

Describe the staffing plan and its relationship to the volume of clients or services to be provided. Describe in terms of staff to client ratios, client volume or case load per staff, or how many staff are needed to perform a particular activity. Any program with the potential to require 24-hour coverage must submit a detailed description of how, by staff position, coverage will be provided.

Agencies providing services at more than one site must include a description of the staffing pattern for each site, if different. If the staffing pattern is the same for each site, include a statement to that effect.

Describe any employment practices that invest in training, that engage employees in organizational improvement projects and promote teamwork.

(Item 28 partially comprises the points scored for Administrative Ability)

(Items 29 and 30 partially comprise the points scored under Staffing Plan)

YEAR 2016 STAFFING REQUIREMENTS-DIRECT SERVICE STAFF *ITEM # 29*

Indicate the number of staff **directly related to achieve your objectives for the program(s) you are applying for**, as indicated by codes 02 and 04 on Forms 2 and 2A. **Executive staff providing direct services to clients should be budgeted as either "Professional Salaries" or "Technical Salaries" on Budget Forms 2 and 2A (Excel spreadsheet referenced in the *Technical Requirements* document).** Provide a job description plus necessary qualifications for each direct service position (sections A & B) (make additional copies as necessary). ***Complete the provider roster*** *(item 30)* ***for current staff working in each program for which a proposal is being submitted.*** If the position is unfilled at the time of proposal submission, indicate the vacancy and provide updated staffing form within 30 days of when position is filled. **For New Applicants for this program, submit calculations showing the agency-wide average of in-service/continuing education hours per direct service provider in the previous year.**

PROGRAM_____ 2016 PROGRAM No._____

POSITION TITLE_____ NO. OF STAFF: _____

Job Description for this position as required to meet the needs of the program specifications. Include qualifications needed to perform job (including certifications or licenses and experience requirements to perform the job). Attach separate sheet, if necessary.

Annual tuition reimbursement granted for this position: $_____

Actual total hours worked for all employees in this position for the 12 months prior to completing this application: _____

Annual turnover for *this position (all employees, full and part-time)*, as measured by total number of separations (including voluntary and involuntary) from this position in the twelve months prior to completing this proposal divided by the total number of employees budgeted in this position for the twelve months prior to completing this proposal (show calculation):
_____/_____=_____

For New Applicants for this program who may not have had previous history employing individuals to provide these services, provide annual turnover for the agency as a whole (show calculation):
_____/_____=_____

CURRENT DIRECT SERVICE PROVIDER AND INDIRECT STAFF (DSP) ROSTER *ITEM # 30*

ITEM 30 is available as a download from: http://county.milwaukee.gov/DHHS_bids

This form should be submitted electronically along with the budget spreadsheet.

CLIENT CHARACTERISTICS CHART

ITEM # 31

ETHNICITY DEFINITIONS

1. **Asian or Pacific Islander**: All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes China, Japan, Korea, the Philippine Islands and Samoa.

2. **Black**: All persons having origins in any of the Black racial groups in Africa.

3. **Hispanic:** All persons of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race. (Excludes Portugal, Spain and other European countries.)

4. **American Indian or Alaskan Native**: All persons having origins in any of the original peoples of North America, and those persons who maintain cultural identification through tribal affiliation or community recognition.

5. **White:** All persons who are not Asian or Pacific Islander, Black, Hispanic, or American Indian or Alaskan Native.

DISABLED DEFINITIONS

A disabled individual is defined pursuant to Section 504 of the Rehabilitation Act of 1973.

1. Any person who has a physical or mental impairment which substantially limits one or more major life activities (e.g., caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working);

2. Any person who has a record of such impairment; or,

3. Any person who is regarded as having such impairment.

Describe your data source for completing this form. If your projected client composition differs from your previous year's actual client composition, describe the basis for the difference.

(Item 31 partially comprises the points scored under Cultural Diversity and Cultural Competence and under Staffing Plan.)

2016 CLIENT CHARACTERISTICS CHART

ITEM # 31

Agency Name _____

Disability/Target Group _____

Program Name _____ **2016 Program #** _____

Facility Name & Address _____

CY 2016 Estimated

1. Unduplicated Count of Clients to be Served/Year (Form 1, Column 1). If your estimate differs from prior year actual, provide an explanation on a separate attached page. For new applicants, include numbers for the program you are currently providing that is most similar to the program you are applying for.

		Number	Percent (%)	Prior year actual
2. Age Group:	a. 0 - 2			
	b. 3 - 11			
	c. 12 - 17			
	d. 18 - 20			
	e. 21 - 35			
	f. 36 - 60			
	g. 61 & over			
	TOTAL			
3. Sex:	a. Female			
	b. Male			
	TOTAL			
4. Ethnicity:	a. Asian or Pacific Islander			
	b. Black			
	c. Hispanic			
	d. American Indian or Alaskan Native			
	e. White			
	TOTAL			
5. Other:	a. Disabled individuals			
	b. Not applicable			
	TOTAL			

Date Submitted:	

The total in each category must be equal to the number in Form 1, Column 1, Total Number of Cases (Clients) to be served per Year.

(Rev 7/15)

HOUSING DIVISION

PROGRAM REQUIRMENTS/DESCRIPTIONS

PART 2

PROGRAM DESCRIPTIONS

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2016 TENTATIVE CONTRACT ALLOCATIONS

HOUSING DIVISION

Recommended Programs		2016 * Tentative Allocations
H 008	Housing Supportive Services - United House	$110,000
H 010	Housing Supportive Services - Fardale	$ 97,154
H 011	Housing Supportive Services – Farwell Studio Apartments	$ 90,000

*The following are **continuing programs** in a multi-year cycle and are **not** open to competitive proposals:*

Recommended Programs		2016 * Tentative Allocations
H 002	Supported Apartment Program	$260,000
H 005	Homeless/Emergency Shelter	$719,000
H 006	Housing Supportive Services – Empowerment Village	$180,000
H 012	Pathways to Permanent Housing	$500,000

H 013	My Home Housing / Tenant-based Rent Assistance Case Management Services	$260,000
H 014	Housing Supportive Services – Highland Commons	$140,000
H 017	Keys to Independence Supportive Housing	$400,000

***Final 2016 allocations are contingent on the 2016 adopted budget.**

Housing Division

The following programs are open for competitive proposals for the 2016 contract period

Housing Supportive Services – United House

Program H-008

Performance Based: Yes (Data Collection Only in 2016)

Program Purpose

Contractor will provide on-site services at the United House permanent supported housing development. These services will assist Milwaukee County Behavioral Health Division consumers with maintaining their individual housing unit and coordinate services with case management.

Required Program Inputs, Processes, and Program Activities

Unit of Service: Client (24 unduplicated)

Services:

- All consumers are referred by CARS contracted case management agency and funded by the County.
- Consumer referrals are screened for appropriateness.
- Consumers meeting the criteria are admitted and oriented to the program.
- After orientation, a consumer signs a lease agreement, program rules sheet and develops a Wellness Recovery Action Plan (WRAP) to maintain their physical and mental health.

Professional staff works with the individual's case manager, Certified Peer Support Specialists and the resident to offer recovery-oriented services.

Certified Peer Support Specialists must complete approved training and pass the certification examination as well as complete continuing education hours (CEH) based on the program's core competencies in order to maintain his/her certification. Certified

Peer Support Specialists will conduct the following ongoing groups under the supervision of professional staff:

- **Mental Health Education Groups** to offer improvements in the categories of self-stigma/insight, identifying symptoms of mental illness and coping techniques. Groups will include discussion groups, role-playing activities, reviewing media coverage (newspaper articles & mental health magazines) and educational games.

- **Groups on Medication Management to** increase understanding of medications and their importance, identify obstacles to compliance and provide/receive peer support. Groups, focusing on Medication Information, common side effects, interactions (nutrition, alcohol, over the counter medications, etc.) and support (peer, group, family, etc.) systems will be offered on a weekly basis.

- **Groups to create Wellness Recovery Action Plans (WRAP**) based on Mary Ellen Copeland's curriculum. Residents will demonstrate improved ability to identify personal factors that may trigger an increase in symptoms and will learn and utilize new self-care tools and strategies to prevent or reduce the severity of such incidents. All will create pre and post crisis plans.

- **Groups on community involvement**, including educational sessions on community resources, advocacy groups, landlord/tenant issues, and trainings on utilizing public transportation.

- **Groups on recovery** utilizing the Recovery Workbook created by the Boston Center for Psychiatric Rehabilitation.

- **Socialization and leisure activities** to increase psychosocial skills, including potlucks, Cooking groups, movie nights and holiday parties.

- **Functional literacy groups** to develop the necessary reading, writing and math skills to function independently.

Certified Peer Support Specialists will predominantly conduct these groups under the supervision of professional staff.

Individual one-on-one activities with 24 residents will include:

- On-site case managements, as well as close communication with CARS case manager
- Ongoing support and direction as needed
- Assistance in establishing personal goals.
- Feedback on recovery.
- Developing independent living skills, including cleaning, meal planning and preparation, laundry, budgeting, shopping and bill paying.
- Ensuring adequate/appropriate nutrition and personal hygiene

Skill development is based on daily use of existing skills, developing new skills and learning how to problem solve

Certified Peer Support Specialists are required to have daily contact with each resident and communicate issues or concerns to other Certified Peer Support Specialists and professional staff via a computerized log. In addition, charts with medical histories and other pertinent information are kept on each resident. Staff will carry an on-call phone.

Residents will be involved in the program planning and implementation. Weekly resident meetings will be held to facilitate communication and promote needed changes.

Non-Billable Activities

Completion of annual leases and documentation for tax credits

Required Documentation

Tenant files must be maintained according to all HUD and WHEDA standards

Annual evaluation report must be submitted to include the format and content specified in the *Purchase of Service Guidelines, Technical Requirements*

Expected Outputs

- At least 17 consumers will participate in recovery oriented group and recreation activities
- 24 consumers will improve in accomplishing their activities of daily living (ADL)
- 24 consumers will show a decrease in mental health symptoms and relapse with substance abuse
- Certified Peer Specialists will participate and complete 20 total hours with at least 1.5 training hours of approved continuing education in the required 5 categories

Expected Outcomes

1. At least 70% of consumers will participate in recovery oriented services
2. 70% of consumers will show an improvement in ADLs
3. 70% of consumers will show a decrease in mental health symptoms or relapse from substance abuse
4. 100% of Certified Peer Specialists will complete 20 hours of approved Continuing Education

Indicators

1. Percentage of consumers participating in recovery oriented services
2. Percentage of consumers improvement with ADLs
3. Percentage of symptom management improvement
4. Percentage of Certified Peer Specialists completing Continuing Education

Performance-Based Program

Beginning in 2016, this program will become a performance-based program. This program will be in the data collection phase in 2016, with actual performance based reimbursements beginning in 2017.

For 2016, three performance measures have been selected for quarterly evaluation (see the following "Expected Levels of Outcome Achievement").

Expected Levels of Outcome Achievement

1. At least 70% of consumers will attend at least one group session per quarter held at United House
2. 70% of United House consumers will show an improvement in ADLs in each quarter
3. 70% of United House consumers will not experience an involuntary hospitalization in each quarter

Outcomes reports for the above measures must be submitted at the close of each quarter along with the monthly invoice.

Housing Supportive Services – Fardale

Program H-010

Performance Based: Yes (Data Collection Only in 2016)

Program Purpose

Contractor will provide on-site services at the Fardale transitional housing program. These services will assist Milwaukee County Behavioral Health Division consumers with maintaining their individual housing unit and coordinate services with case management.

Required Program Inputs, Processes, and Program Activities

Unit of Service: Client (38 unduplicated)

Services:

- All consumers are referred by CARS and funded by the County.
- Consumer referrals are screened for appropriateness.
- Consumers meeting the criteria are admitted and oriented to the program.
- After orientation, a consumer signs a lease agreement, program rules sheet and develops a Wellness Recovery Action Plan (WRAP) to maintain their physical and mental health.

Professional staff works with the individual's case manager, Certified Peer Support Specialists and the resident to offer recovery-oriented services.

Certified Peer Support Specialists must complete approved training and pass the certification examination as well as complete continuing education hours (CEH) based on the program's core competencies in order to maintain his/her certification. Certified Peer Support Specialists will conduct the following ongoing groups under the supervision of professional staff:

- **Mental Health Education Groups** to offer improvements in the categories of self-stigma/insight, identifying symptoms of mental illness and coping techniques. Groups will include discussion groups, role-playing activities, reviewing media coverage (newspaper articles & mental health magazines) and educational games.

- **Groups on Medication Management to** increase understanding of medications and their importance, identify obstacles to compliance and provide/receive peer support. Groups, focusing on medication information, common side effects, interactions (nutrition, alcohol, over the counter medications, etc.) and support (peer, group, family, etc.) systems will be offered on a weekly basis.
- **Groups to create Wellness Recovery Action Plans (WRAP**) based on Mary Ellen Copeland's curriculum. Residents will demonstrate improved ability to identify personal factors that may trigger an increase in symptoms and will learn and utilize new self-care tools and strategies to prevent or reduce the severity of such incidents. All will create pre and post crisis plans.
- **Groups on community involvement**, including educational sessions on community resources, advocacy groups, landlord/tenant issues, and trainings on utilizing public transportation.
- **Groups on recovery** utilizing the Recovery Workbook created by the Boston Center for Psychiatric Rehabilitation.
- **Socialization and leisure activities** to increase psychosocial skills, including potlucks, Cooking groups, movie nights and holiday parties.
- **Functional literacy groups** to develop the necessary reading, writing and math skills to function independently.

Certified Peer Support Specialists will predominantly conduct these groups under the supervision of professional staff.

Individual one-on-one activities with 38 residents will include:

- On-site case management, as well as close communication with CARS case manager
- Ongoing support and direction as needed
- Assistance in establishing personal goals.
- Feedback on recovery.
- Developing independent living skills, including cleaning, meal planning and preparation, laundry, budgeting, shopping and bill paying.
- Ensuring adequate/appropriate nutrition and personal hygiene

Skill development is based on daily use of existing skills, developing new skills and learning how to problem solve

Certified Peer Support Specialists are required to have daily contact with each resident and communicate issues or concerns to other Certified Peer Support Specialists and professional staff via a computerized log. In addition, charts with medical histories and other pertinent information are kept on each resident. Staff will carry an on-call phone.

Residents will be involved in the program planning and implementation. Weekly resident meetings will be held to facilitate communication and promote needed changes.

Non-Billable Activities

Participation on various mental health and housing related committees and membership in community groups

Required Documentation

Resident case records maintained by the agency shall include daily attendance logs, activities of daily living and progress towards treatment goals. Resident files must demonstrate coordination with the CARS case manager.

Annual evaluation report must be submitted to include the format and content specified in the *Purchase of Service Guidelines, Technical Requirements*

Expected Outputs

- At least 27 consumers will participate in recovery oriented group and recreation activities
- 38 consumers will improve in accomplishing their activities of daily living (ADL)
- 38 consumers will show a decrease in mental health symptoms and relapse with substance abuse
- Certified Peer Specialists will complete 20 total hours with at least 1.5 training hours of approved continuing education in the required 5 categories

Expected Outcomes

1. At least 70% of consumers will participate in recovery oriented services
2. 70% of consumers will show an improvement in ADLs
3. 70% of consumers will show a decrease in mental health symptoms or relapse from substance abuse
4. 100% of Certified Peer Specialists will complete 20 hours of approved continuing education

Indicators

1. Percentage of consumers participating recovery oriented services
2. Percentage of consumers improvement with ADLs
3. Percentage of symptom management improvement
4. Percentage of Certified Peer Specialists completing continuing education

Performance-Based Program

Beginning in 2016, this program will become a performance-based program. This program will be in the data collection phase in 2016, with actual performance based reimbursements beginning in 2017.

For 2016, three performance measures have been selected for quarterly evaluation (see the following “Expected Levels of Outcome Achievement”).

Expected Levels of Outcome Achievement

1. At least 70% of consumers will attend at least one group session per quarter held at Fardale Supported Apartments
2. 70% of consumers will show an improvement in ADLs in each quarter
3. 70% of consumers will not experience an involuntary hospitalization in each quarter

Outcomes reports for the above measures must be submitted at the close of each quarter along with the monthly invoice.

Housing Supportive Services – Farwell Studio Apartments

Program H-011

Performance Based: Yes (Data Collection Only in 2016)

Program Purpose

Contractor will provide on-site services at the Farwell Studio Apartments permanent supported housing development. These services will assist Milwaukee County Behavioral Health Division consumers with maintaining their individual housing unit and coordinate services with case management.

Required Program Inputs, Processes, and Program Activities

Unit of Service: Client (17 unduplicated)

Services:

- All consumers are referred by CARS contracted case management agency and funded by the County.
- Consumer referrals are screened for appropriateness.
- Consumers meeting the criteria are admitted and oriented to the program.
- After orientation, a consumer signs a lease agreement, program rules sheet and develops a Wellness Recovery Action Plan (WRAP) to maintain their physical and mental health.

Professional staff works with the individual's case manager, Certified Peer Support Specialists and the resident to offer recovery-oriented services.

Certified Peer Support Specialists must complete approved training and pass the certification examination as well as complete continuing education hours (CEH) based on the program's core competencies in order to maintain his/her certification. Certified Peer Support Specialists will conduct the following ongoing groups under the supervision of professional staff:

- **Mental Health Education Groups** to offer improvements in the categories of self-stigma/insight, identifying symptoms of mental illness and coping techniques. Groups will include discussion groups, role-playing activities, reviewing media coverage (newspaper articles & mental health magazines) and educational games.

- **Groups on Medication Management to** increase understanding of medications and their importance, identify obstacles to compliance and provide/receive peer support. Groups, focusing on medication information, common side effects, interactions (nutrition, alcohol, over the counter medications, etc.) and support (peer, group, family, etc.) systems will be offered on a weekly basis.

- **Groups to create Wellness Recovery Action Plans (WRAP**) based on Mary Ellen Copeland's curriculum. Residents will demonstrate improved ability to identify personal factors that may trigger an increase in symptoms and will learn and utilize new self-care tools and strategies to prevent or reduce the severity of such incidents. All will create pre and post crisis plans.

- **Groups on community involvement**, including educational sessions on community resources, advocacy groups, landlord/tenant issues, and trainings on utilizing public transportation.

- **Groups on recovery** utilizing the Recovery Workbook created by the Boston Center for Psychiatric Rehabilitation.

- **Socialization and leisure activities** to increase psychosocial skills, including potlucks, Cooking groups, movie nights and holiday parties.

- **Functional literacy groups** to develop the necessary reading, writing and math skills to function independently.

Individual one-on-one activities with 17 residents will include:

- On-site case managements, as well as close communication with CARS case manager
- Ongoing support and direction as needed
- Assistance in establishing personal goals
- Feedback on recovery
- Developing independent living skills, including cleaning, meal planning and preparation, laundry, budgeting, shopping and bill paying
- Ensuring adequate/appropriate nutrition and personal hygiene

Skill development is based on daily use of existing skills, developing new skills and learning how to problem solve

Certified Peer Support Specialists are required to have daily contact with each resident and communicate issues or concerns to other Certified Peer Support Specialists and professional staff via a computerized log. In addition, charts with medical histories and other pertinent information are kept on each resident. Staff will carry an on-call phone.

Residents will be involved in the program planning and implementation. Weekly resident meetings will be held to facilitate communication and promote needed changes.

Non-Billable Activities

Completion of annual leases and documentation for tax credits

Special Budget Consideration

Part of your budget for this program must include a monthly payment of $1,000 for office rent in the Farwell Studio building.

Required Documentation

Tenant files must be maintained according to all HUD and WHEDA standards

Annual evaluation report must be submitted to include the format and content specified in the *Purchase of Service Guidelines, Technical Requirements*

Expected Outputs

- At least 12 consumers will participate in recovery oriented group and recreation activities
- 17 consumers will improve in accomplishing their activities of daily living (ADL).
- 17 consumers will show a decrease in mental health symptoms and relapse with substance abuse.
- Certified Peer Specialists will participate and complete 20 total hours with at least 1.5 training hours of approved continuing education in the required 5 categories

Expected Outcomes

1. At least 70% of consumers will participate in recovery oriented services
2. 70% of consumers will show an improvement in ADLs.
3. 70% of consumers will show a decrease in mental health symptoms or relapse from substance abuse.
4. 100% of Certified Peer Specialists will complete 20 hours of approved Continuing Education

Indicators

1. Percentage of consumers participating in recovery oriented services
2. Percentage of consumers improvement with ADLs
3. Percentage of symptom management improvement
4. Percentage of Certified Peer Specialists completing Continuing Education

Performance-Based Program

Beginning in 2016, this program will become a performance-based program. This program will be in the data collection phase in 2016, with actual performance based reimbursements beginning in 2017.

For 2016, three performance measures have been selected for quarterly evaluation (see the following "Expected Levels of Outcome Achievement").

Expected Levels of Outcome Achievement

1. At least 70% of consumers will attend at least one group session per quarter held at Farwell Studio Apartments.
2. 70% of Farwell Studio consumers will show an improvement in ADLs in each quarter.
3. 70% of consumers will not experience an involuntary hospitalization in each quarter.

Outcomes reports for the above measures must be submitted at the close of each quarter along with the monthly invoice.

FOLLOWING PROGRAMS ARE NOT OPEN FOR COMPETITIVE PROPOSAL

The following Housing Division programs are currently in a multi-year contract cycle. These program descriptions are being provided for the information of the current contractors:

SUPPORTED APARTMENT PROGRAM

Program H-002

Program Purpose

The Supported Apartment Program is a transitional housing program that provides services to persons having a serious and persistent mental illness with a living environment that provides the support necessary for an individual to live as independently as possible within an apartment setting. The Supported Apartments are fully furnished including appliances.

Required Program Inputs, Processes, and Program Activities

Services provided by the Supported Apartment Program will include collaborating with the CARS contracted case manager to encourage the consumer to work towards their treatment goals, provide prompts to complete activities of daily living including cooking, attendance at day programs, social support including recreational activities and community meals, and medication education and symptom management. The Supported Apartment Program facility staff in conjunction will provide these services with other members of the consumer's support network. Consumers living at the Supported Apartment Program are expected to pay a monthly rent.

Enrollment into a Supported Apartment Program is implemented through a referral from the Special Needs Housing Program. The Special Needs Housing Program will assess the need for a supported apartment and make referrals to contract service providers.

It is the policy of the Milwaukee County Housing Division that individuals referred for Supported Apartment Placement by the CARS contracted case management agency, will have an evaluation completed and a decision regarding admission will be reported within fourteen business days of receipt of that referral.

It is the policy of The Housing Division that when a Supported Apartment Program resident is admitted to a psychiatric inpatient unit, the Supported Apartment Program Manager responsible for that client must contact the appropriate inpatient team within one business day of the admission in order to assist in the development of a plan of discharge.

The tentative total budget for the program is $260, 000

Non-Billable Activities

Participation on various mental health and housing related committees and membership in community groups

Required Documentation

Resident case records maintained by the agency shall include daily attendance logs, activities of daily living and progress towards treatment goals. Resident files must demonstrate coordination with the CARS contracted case manager.

Annual evaluation report must be submitted to include the format and content specified in the *Purchase of Service Guidelines, Technical Requirements*.

Expected Outputs

- Approximately 50 consumers, accounting for turnover, will be provided symptom management and mentoring of daily living for optimal effectiveness and low levels of relapse
- Each consumer will have a completed financial profile to include a monthly budget and identification of money management skills within 60 days of moving in
- Consumers medical needs will be identified within 60 days of moving in
- Assist and support consumers in keeping safe housing
- Consumers will have a community living plan that addresses future housing needs within 180 days of moving in
- Consumers participate in their own treatment planning process at least twice a year

Expected Outcomes

1. Consumers will attain an optimal level of living skills to reduce and manage symptoms
2. Consumers will have a financial profile indicating income and benefits along with a monthly budget
3. Medical issues will be incorporated in every treatment plan
4. Consumers will be able to move into permanent housing upon completion of the program

5. Consumers will retain permanent housing
6. Consumers will achieve a level of recovery that allows for a decrease in crisis services.

Indicators

1. The number and percentage of all program consumers who are able to demonstrate reduced symptoms and side effects by successfully completing activities of daily living
2. The number and percentage of all program consumers who have a financial profile and adhere to the budget created
3. The number and percentage of consumers who have treatment plans with medical issues incorporated and follow up scheduled with appropriate community providers
4. The number and percentage of all program consumers who are able to move into independent permanent housing upon completion of the program
5. The number and percentage of consumers who retain permanent housing
6. The number and percentage of consumers who are seen at PCS with decreasing frequency

Expected Levels of Outcome Achievement

1. 80% of consumers will demonstrate reduced symptoms and side effects
2. 100% of consumers will have a financial profile and budget within 60 days
3. 100% of consumers will have treatment plans that include medical issues within 60 days
4. 70% of consumers will move into independent permanent housing upon completion of the program
5. 70% of consumers will successfully retain permanent housing one year after completion of the program
6. 70% of consumers will have decreased contact with PCS during the program period

HOMELESS/EMERGENCY SHELTER CARE
PROGRAM H-005

Program Purpose

Homeless/Emergency Shelter Care services provide short term services, often under emergency conditions, in an alternate setting, to adults, families, and victims of domestic violence, who need a temporary place to stay pending resolution of problems in their home or life, or until an appropriate living setting can be secured.

Required Program Inputs, Processes, and Program Activities

Services must include, but are not limited to, relocation to permanent or transitional housing (may include support services), linkage to income/employment/entitlements, access to food, supervision at the shelter site, and short-term case management.

Every possible effort must be made to provide readily available access to persons who are not able to communicate fluently in English.

The tentative total budget for the program is $418,000

Non-Billable Activities

Emergency Shelter Care does not include services related to the management of transitional or permanent housing, to AODA treatment programming, or to mental health programming (although those services may be goals and referral sources and may be integral to the shelter stay component). Emergency Shelter Care is limited to the actual bed nights provided in the agency shelter facility as calculated in a per diem.

Required Documentation

All emergency shelter agencies under contract to Milwaukee County Housing Division will be required to participate in the Homeless Management Information System, the most common of which is Service Point. Agencies must meet quality of data standards set by HUD.

Annual evaluation report must be submitted to include the format and content specified in the *Purchase of Service Guidelines, Technical Requirements*

Expected Outputs

- Each resident of the individual shelter will receive training in homeless prevention techniques, financial management, and personal/family skills.
- Each agency is expected to develop an action plan for each client, which will focus on employment or benefit acquisition.

Expected Outcomes

1. Clients receive dignified shelter and related programming, utilizing all available shelter beds.
2. Clients are able to identify additional community resources and set forth individualized goals.
3. Clients are able to prevent future homeless episodes

Indicators

1. The number of people that applied for shelter compared to the number of people accepted into shelter.
2. Exit interviews will be conducted to ensure clients have met the goals set forth in their individualized plan.
3. The number of clients leaving the shelter who have secured appropriate transitional or permanent housing.

Expected Levels of Outcome Achievement

1. Each shelter will operate at a minimum of 90% capacity.
2. 70% of residents will obtain either transitional or permanent housing upon discharge.
3. 50% or residents will establish income upon discharge.

Housing Supportive Services – Empowerment Village
Lincoln and National Sites

Program H-006

NOTE: The following descriptions for Empowerment Village list the two sites separately for the information of proposers. However, the Housing Division seeks proposals to provide services to both sites as a combined program. The tentative total budget for the program is $180,000.

Empowerment Village - Lincoln

Program Purpose

Contractor will provide on-site services at the Empowerment Village **Lincoln** permanent supported housing development. These services will assist Milwaukee County Behavioral Health Division consumers with maintaining their individual housing unit and coordinate services with case management.

Required Program Inputs, Processes, and Program Activities

Services:

- All consumers are referred by BHD-CARS contracted case management agency and funded by the County.
- Consumer referrals are screened for appropriateness.
- Consumers meeting the criteria are admitted and oriented to the program.
- After orientation, a consumer signs a lease agreement, program rules sheet and develops a Wellness Recovery Action Plan (WRAP) to maintain their physical and mental health.

Professional staff works with the individual's case manager, Certified Peer Support Specialists and the resident to offer recovery-oriented services.

Certified Peer Support Specialists must complete approved training and pass the certification examination as well as complete continuing education hours (CEH) based on the program's core competencies in order to maintain his/her certification. Certified Peer Support Specialists will conduct the following groups under the supervision of professional staff:

- **Mental Health Education Groups** to offer improvements in the categories of self-stigma/insight, identifying symptoms of mental illness and coping techniques. Groups will include discussion groups, role-playing activities, reviewing media coverage (newspaper articles & mental health magazines) and educational games.

- **Groups on Medication Management to** increase understanding of medications and their importance, identify obstacles to compliance and provide/receive peer support. Groups, focusing on medication information, common side effects, interactions (nutrition, alcohol, over the counter medications, etc.) and support (peer, group, family, etc.) systems will be offered on a weekly basis.

- **Groups to create Wellness Recovery Action Plans (WRAP**) based on Mary Ellen Copeland's curriculum. Residents will demonstrate improved ability to identify personal factors that may trigger an increase in symptoms and will learn and utilize new self-care tools and strategies to prevent or reduce the severity of such incidents. All will create pre and post crisis plans.

- **Groups on community involvement**, including educational sessions on community resources, advocacy groups, landlord/tenant issues, and trainings on utilizing public transportation.

- **Groups on recovery** utilizing the Recovery Workbook created by the Boston Center for Psychiatric Rehabilitation.

- **Socialization and leisure activities** to increase psychosocial skills, including potlucks, Cooking groups, movie nights and holiday parties.

- **Functional literacy groups** to develop the necessary reading, writing and math skills to function independently.

Individual one-on-one activities with 30 residents will include:

- On-site case managements, as well as close communication with SAIL case manager
- Ongoing support and direction as needed
- Assistance in establishing personal goals.
- Feedback on recovery.
- Developing independent living skills, including cleaning, meal planning and preparation, laundry, budgeting, shopping and bill paying.
- Ensuring adequate/appropriate nutrition and personal hygiene

Skill development is based on daily use of existing skills, developing new skills and learning how to problem solve

Certified Peer Support Specialists are required to have daily contact with each resident and communicate issues or concerns to other Certified Peer Support Specialists and professional staff via a computerized log. In addition, charts with medical histories and other pertinent information are kept on each resident. Staff will carry an on-call phone.

Residents will be involved in the program planning and implementation. Weekly resident meetings will be held to facilitate communication and promote needed changes.

Non-Billable Activities

Completion of annual leases and documentation for tax credits.

Required Documentation

Tenant files must be maintained according to all HUD and WHEDA standards.

Annual evaluation report must be submitted to include the format and content specified in the *Purchase of Service Guidelines, Technical Requirements*

Expected Outputs

- 30 consumers will maintain their supportive housing placement
- All 30 BHD units will remain occupied
- 30 consumers will improve in accomplishing their activities of daily living (ADL).
- 30 consumers will show a decrease in mental health symptoms and relapse with substance abuse.

Expected Outcomes

1. At least 80% of consumers will successfully complete a year lease at Empowerment Village Lincoln.
2. 100% of units reserved for BHD consumers will remain occupied, allowing one month for the turnover of units.
3. 70% of consumers will show an improvement in ADLs.
4. 70% of consumers will show a decrease in mental health symptoms or relapse from substance abuse.

Indicators

1. Percentage of consumers completing leases
2. Percentage of units occupied
3. Percentage of consumers improvement with ADLs
4. Percentage of symptom management improvement

Expected Levels of Outcome Achievement

1. At least 80% of consumers will successfully complete a year lease at Empowerment Village Lincoln.
2. 100% of units reserved for BHD consumers will remain occupied, allowing one month for the turnover of units.
3. 70% of consumers will show an improvement in ADLs.
4. 70% of consumers will show a decrease in mental health symptoms or relapse from substance abuse.

Empowerment Village - National

Program Purpose

Contractor will provide on-site services at the Empowerment Village **National** permanent supported housing development. These services will assist Milwaukee County Behavioral Health Division consumers with maintaining their individual housing unit and coordinate services with case management.

Required Program Inputs, Processes, and Program Activities

Services:

- All consumers are referred by BHD-CARS contracted case management agency and funded by the County.
- Consumer referrals are screened for appropriateness.
- Consumers meeting the criteria are admitted and oriented to the program.
- After orientation, a consumer signs a lease agreement, program rules sheet and develops a Wellness Recovery Action Plan (WRAP) to maintain their physical and mental health.

Professional staff works with the individual's case manager, Certified Peer Support Specialists and the resident to offer recovery-oriented services.

Certified Peer Support Specialists must complete approved training and pass the certification examination as well as complete continuing education hours (CEH) based on the program's core competencies in order to maintain his/her certification. Certified Peer Support Specialists will conduct the following groups under the supervision of professional staff:

- **Mental Health Education Groups** to offer improvements in the categories of self-stigma/insight, identifying symptoms of mental illness and coping techniques. Groups will include discussion groups, role-playing activities, reviewing media coverage (newspaper articles & mental health magazines) and educational games.

- **Groups on Medication Management to** increase understanding of medications and their importance, identify obstacles to compliance and provide/receive peer support. Groups, focusing on medication information, common side effects, interactions (nutrition, alcohol, over the counter medications, etc.) and support (peer, group, family, etc.) systems will be offered on a weekly basis.

- **Groups to create Wellness Recovery Action Plans (WRAP**) based on Mary Ellen Copeland's curriculum. Residents will demonstrate improved ability to

identify personal factors that may trigger an increase in symptoms and will learn and utilize new self-care tools and strategies to prevent or reduce the severity of such incidents. All will create pre and post crisis plans.

- **Groups on community involvement**, including educational sessions on community resources, advocacy groups, landlord/tenant issues, and trainings on utilizing public transportation.

- **Groups on recovery** utilizing the Recovery Workbook created by the Boston Center for Psychiatric Rehabilitation.

- **Socialization and leisure activities** to increase psychosocial skills, including potlucks, Cooking groups, movie nights and holiday parties.

- **Functional literacy groups** to develop the necessary reading, writing and math skills to function independently.

Individual one-on-one activities with 35 residents will include:

- On-site case managements, as well as close communication with CARS case manager
- Ongoing support and direction as needed
- Assistance in establishing personal goals.
- Feedback on recovery.
- Developing independent living skills, including cleaning, meal planning and preparation, laundry, budgeting, shopping and bill paying.
- Ensuring adequate/appropriate nutrition and personal hygiene

Skill development is based on daily use of existing skills, developing new skills and learning how to problem solve

Certified Peer Support Specialists are required to have daily contact with each resident and communicate issues or concerns to other Certified Peer Support Specialists and professional staff via a computerized log. In addition, charts with medical histories and other pertinent information are kept on each resident. Staff will carry an on-call phone.

Residents will be involved in the program planning and implementation. Weekly resident meetings will be held to facilitate communication and promote needed changes.

Non-Billable Activities

Completion of annual leases and documentation for tax credits.

Required Documentation

Tenant files must be maintained according to all HUD and WHEDA standards.

Annual evaluation report must be submitted to include the format and content specified in the *Purchase of Service Guidelines, Technical Requirements*

Expected Outputs

- 35 consumers will maintain their supportive housing placement
- All 35 BHD units will remain occupied
- 35 consumers will improve in accomplishing their activities of daily living (ADL).
- 35 consumers will show a decrease in mental health symptoms and relapse with substance abuse.

Expected Outcomes

1. At least 80% of consumers will successfully complete a year lease at Empowerment Village National.
2. 100% of units reserved for BHD consumers will remain occupied, allowing one month for the turnover of units.
3. 70% of consumers will show an improvement in ADLs.
4. 70% of consumers will show a decrease in mental health symptoms or relapse from substance abuse.

Indicators

1. Percentage of consumers completing leases
2. Percentage of units occupied
3. Percentage of consumers improvement with ADLs
4. Percentage of symptom management improvement

Expected Levels of Outcome Achievement

1. At least 80% of consumers will successfully complete a year lease at Empowerment Village National.
2. 100% of units reserved for BHD consumers will remain occupied, allowing one month for the turnover of units.
3. 70% of consumers will show an improvement in ADLs.
4. 70% of consumers will show a decrease in mental health symptoms or relapse from substance abuse.

Pathways to Permanent Housing (Transitional Housing)

Program H-012

Program Purpose

Pathways to Permanent Housing transitional housing program will serve a variety of community needs. The program will target individuals who are either ready to be discharged from an institution or are coming out of a setting such as Crisis Stabilization House or the Community Resource Center. Pathways to Permanent Housing will also be an alternative for individuals transitioning from a Community Based Residential Facility (CBRF) and give consumers an additional housing option for those on CBRF waiting lists.

A portion of these units may also be used for individuals who are at risk of being homeless.

Pathways to Permanent Housing focuses on moving consumers through the housing continuum from day one. On-site staff will begin discussing permanent housing goals upon admission and that will become part of the individual's treatment plan. Staff will work with consumers on activities of daily living including cooking classes and vocational training on-site with the focus on preparing individuals to move into permanent housing. This has traditionally been a barrier for consumers to move into a more independent housing setting.

The tentative total budget for the program is $500,000

Required Program Inputs, Processes, and Program Activities

Services:

- All consumers are referred by community providers
- Consumer referrals are screened for appropriateness.
- Consumers meeting the criteria are admitted and oriented to the program.
- After orientation, a consumer signs a program rules sheet and develops a Wellness Recovery Action Plan (WRAP) to maintain their physical and mental health.

Staff works with the consumer's case manager or community provider, if applicable, or coordinates connection to community services and provider(s). Certified Peer Support Specialists work with the consumer to offer recovery-oriented services.

Certified Peer Support Specialists must complete approved training and pass the certification examination as well as complete continuing education hours (CEH) based on the program's core competencies in order to maintain his/her certification. Certified Peer Support Specialists will conduct the following ongoing groups under the supervision of professional staff:

- **Mental Health Education Groups** to offer improvements in the categories of self-stigma/insight, identifying symptoms of mental illness and coping techniques. Groups will include discussion groups, role-playing activities, reviewing media coverage (newspaper articles & mental health magazines) and educational games.

- **Groups on Medication Management to** increase understanding of medications and their importance, identify obstacles to compliance and provide/receive peer support. Groups, focusing on medication information, common side effects, interactions (nutrition, alcohol, over the counter medications, etc.) and support (peer, group, family, etc.) systems will be offered on a weekly basis.

- **Groups to create Wellness Recovery Action Plans (WRAP**) based on Mary Ellen Copeland's curriculum. Residents will demonstrate improved ability to identify personal factors that may trigger an increase in symptoms and will learn and utilize new self-care tools and strategies to prevent or reduce the severity of such incidents. All will create pre and post crisis plans.

- **Groups on community involvement**, including educational sessions on community resources, advocacy groups, landlord/tenant issues, and trainings on utilizing public transportation.

- **Groups on recovery** utilizing the Recovery Workbook created by the Boston Center for Psychiatric Rehabilitation.

- **Socialization and leisure activities** to increase psychosocial skills, including potlucks, Cooking groups, movie nights and holiday parties.

- **Functional literacy groups** to develop the necessary reading, writing and math skills to function independently.

Individual one-on-one activities with 27 consumers will include:

- On-site case management, as well as close communication with community providers
- Ongoing support and direction as needed
- Assistance in establishing personal goals
- Feedback on recovery

- Developing independent living skills, including cleaning, meal planning and preparation, laundry, budgeting, shopping and bill paying
- Ensuring adequate/appropriate nutrition and personal hygiene

Skill development is based on daily use of existing skills, developing new skills and learning how to problem solve

Certified Peer Support Specialists are required to have daily contact with each resident and communicate issues or concerns to other Certified Peer Support Specialists and professional staff via a computerized log. In addition, charts with medical histories and other pertinent information are kept on each resident. Staff will carry an on-call phone.

Consumers will be involved in the program planning and implementation. Weekly resident meetings will be held to facilitate communication and promote needed changes

Non-Billable Activities

Participation on various mental health and housing related committees and membership on community groups

Required Documentation

Consumer files maintained by the agency shall include daily attendance logs, activities of daily living and progress towards treatment goals. Consumer files must demonstrate coordination with any community services and providers.

Annual evaluation report must be submitted to include the format and content specified in the *Purchase of Service Guidelines, Technical Requirements*

Expected Outputs

- 27 beds will remain occupied
- 27 consumers will have a completed needs assessment upon admission
- Symptom management and mentoring of daily living for optimal effectiveness and low levels of relapse will occur daily for 27 consumers
- 27 consumers will improve in accomplishing their activities of daily living (ADL)
- Daily groups and activities will be offered on-site to 27 consumers
- 27 consumers will find permanent housing

Expected Outcomes

1. Consumers will have safe temporary housing
2. Consumers will obtain and/or remain connected with community provider(s)
3. Consumers will obtain an optimal level of living skills to reduce and manage symptoms
4. Consumers will participate in evaluations of daily living skills
5. Consumers will participate in activities that are available
6. Consumers will work with staff to find appropriate housing

Indicators

1. Percent of consumers having safe temporary housing
2. Percent of consumers obtaining and/or remaining connected to community providers throughout residency at Pathways to Permanent Housing
3. Percent of consumers demonstrating reduced symptoms and side effects
4. Percent of consumers demonstrating improvement in daily living skills
5. Percent of residents participating in activities that are available to indicate their level of independence as it relates to finding appropriate housing
6. Percent of residents working with staff who are able to successfully discharge into the least restrictive permanent housing placement

Expected Levels of Outcome Achievement

1. 100% of consumers have safe temporary housing
2. 100% of consumers are connected to community providers
3. 80% of consumers will demonstrate reduced symptoms and side effects
4. 80% of consumers will demonstrate improvement of daily living skills
5. 40% of consumers will be actively engaged in offered services and activities
6. 80% or residents will successfully discharge to permanent housing

My Home Housing / Tenant-based Rent Assistance
Case Management Services

Program H-013

Program Purpose

The My Home Housing Program, (formerly known as Shelter Plus Care TRA) is a permanent housing program, providing tenant-based rent assistance and supportive services to individuals who are homeless and disabled, and who lack the resources and support networks to access other permanent housing. While participating in this tenant-based rent assistance program, individuals and families can choose a suitable unit anywhere in Milwaukee County.

This program is a large collaboration with over 20 community agencies (partner agencies) and has historically served the target populations of homeless people living with severe mental illness, chronic substance abuse and/or HIV/AIDS. Individuals and families referred must meet the criteria for Category 1–Literally Homeless (public or private place not meant for habitation, emergency shelter or transitional housing for homeless) or Category 4-Fleeing Attempting to Flee Domestic Violence. Additionally, applicants should be able to live independently.

Required Program Inputs, Processes, and Program Activities

Participation in the My Home Housing Program begins with a referral to the program from a partner agency's case manager. Referrals must include documentation of homeless status and verification of disability. My Home staff reviews referrals to determine whether eligibility criteria are met. If found eligible, the referral will be staffed with the case manager and applicant to review program requirements and expectations, and to determine whether the program and the individual are a suitable match.

A condition of program participation is that participants are required to work with a case manager and engage in supportive services for as long as Program benefits are received. As a result of this requirement, the case manager's role in maintaining housing is critical. The case manager must also be very diligent in the preparation of the service plan and the delivery of case management services. In view of the close relationship between the service plan (services) and the maintenance of permanent housing, the case manager should be prepared to do relatively intense case management during the initial months of the tenancy and whenever the needs of the participant warrant intensive case management. At no time during Program participation, may the participant be discharged from case management.

Existing caseloads requiring case management services

Caseload A -- 40 Individual and/or family households.
Disabilities: Primarily chronic substance abuse and/or serious mental illness
Caseload A Total Tentative Budget: $130,000

Caseload B – 20 Individual households – Hard-to-serve, chronically homeless
Disabilities: Primarily serious mental illness and/or chronic substance abuse

Caseload B -- 15 Family households
Disabilities: Primarily chronic substance abuse
Caseload B Total Tentative Budget: $130,000

The tentative total budget for the program is $260,000. Responding agencies may apply to provide services to either or both caseloads. If both caseloads, please enter each as a separate program in the budget spreadsheet, and address each caseload separately in the Program Proposal.

Non-Billable Activities

Participation on various mental health and housing related committees and membership in community groups

Required Documentation

Client Case Files must be maintained by the agency and shall include case notes regarding all contacts, referrals, and follow up actions; a client needs assessment, initial and updated service plan and progress in addressing client's needs and achievement of goals.

Service Match Reports must be submitted monthly by the agency for each participant, documenting the services received by the participant during the month. Reports are to be submitted to the program by the 10th day each month.

Outcome Reports Quarterly Outcome Reports must be submitted within 30 days of the end of the quarter and an annual Outcome Report at the end of the service year

Annual evaluation report must be submitted to include the format and content specified in the *Purchase of Service Guidelines, Technical Requirements*.

Expected Outputs
For a caseload of 75

Service Plan: The case manager must prepare a service plan with each participant, based on an assessment of the participant's needs. The service plan should address the client's individual needs and should include a plan for making sure that the client is receiving appropriate services so that housing is maintained.

Role In Housing Process: The case manager must assist the participant in every aspect of the housing process. This includes collecting the necessary information for the housing eligibility interview, scheduling and attending the housing appointments, locating an appropriate unit, working with the landlord, submitting the necessary papers for the inspection process, making sure that leases are signed, explaining the lease terms to the participant, and making sure that all the necessary paperwork is returned to the Housing Office.

Maintaining Housing: It is necessary for the case manager to be very active in assisting the participant in fulfilling all the housing responsibilities. There should be regular contact with the participant until the case manager is certain that the participant is stable and comfortable in the housing. Initially, an in-home visit should occur at least once a week, however for some participants, daily visits may be necessary until the participant is stable in the new environment. Once stable the case manager should have contact with the participant as often as is necessary to maintain stability in housing.

Home Visits: At minimum, two in-home visits are a monthly requirement. During the in-home visit, the case manager should deal with any concerns related to maintaining stable housing, including areas such as money management, housekeeping or any neighbor/landlord issues.

Communications With the Landlord/Property Management: The case manager should be in regular contact with the landlord/property management. The case manager must be available to the landlord/property management if tenancy issues occur and must aggressively work to resolve any difficulties. Regular contact is recommended to assure that everything is working out well. When the landlord/property management contacts the case manager about any concern regarding the tenancy, the case manager should respond to the landlord immediately and address the landlord's concern in a timely manner.

Communications With the My Home Housing Program Office: If problems arise that cannot be worked out with the landlord and/or the program participant, the case manager should contact the housing representative to discuss the matter and pursue resolution of the issue. If any matter arises which threatens the participant's housing, the housing representative should be contacted immediately. Housing representatives are available to meet with the case manager and program participant to establish a corrective action plan to assist the participant in maintaining his/her housing.

Case Manager As Proxy: Every case manager must sign a Proxy Statement for the participant. As the participant's proxy, the case manager is authorized (and is expected) to fulfill the participant's housing responsibilities on the participant's behalf, including attending the participant's eligibility interview at initial certification and the annual recertification process. The case manager may not sign forms on behalf of the participant.

Annual Recertification Process: Approximately four months prior to the lease expiration, the Program will mail a notice to the case manager, participant, and landlord advising all parties of the recertification responsibilities that must be fulfilled. It is the case manager's responsibility to make sure that all the responsibilities are taken care of.

Case Manager As Emergency Contact Person: The role of the case manager is critical to the success of the participant, and it is likely that the case manager will be the first person contacted by the landlord if there is an emergency. It is essential that the Housing Office be notified immediately if there is a new case manager assigned to the participant. The agency should fill out a Case Manager Change Form and a new Proxy Statement and return them to the Housing Office.

Administrative responsibilities

Meetings: On an as needed basis the Housing Program Manager and/or housing representatives will schedule meetings with the agency to discuss program operations and to resolve any Program issues. At least one meeting will occur annually.

Outcomes: The agency is responsible for collecting data and monitoring the outcomes specified in the contract. A quarterly Outcome Report is required within 30 days of the end of the quarter and an annual Outcome Report is due within 30 days of the end of the contract

Audits: During the course of the contract, audits by HUD or other authorized parties may be conducted. As part of the audit process, the agency must cooperate and supply information requested by auditors. This includes, but is not limited to, providing client file information related to supportive services provided and supporting information for the data included in the monthly Service Match Reports.

Ad Hoc Reports: Occasionally, there may be a request to prepare a special report or provide other information on various aspects of the My Home Housing program. When these requests occur, it is expected that the agency will be cooperative in responding to the request. Usually the Housing Program Manager on behalf of the requestor will present the request.

HMIS System: Milwaukee County Housing Division-Special Needs Housing Programs is a participant in the Milwaukee CoC's Homeless Management Information System (HMIS). Milwaukee County is responsible for the entry of data on My Home Housing Program participants into the HMIS system at the following times: The Agency must provide the Program with the documents containing this information.

Expected Outcomes

1. Program participants will remain in permanent housing, or exit to other permanent housing.
2. Program participants will maintain their housing units to meet HQS requirements
3. Program participants pay their portion of the rent and the utilities that are not paid for by the landlord
4. Program participants develop and comply with case/service plan developed with case manager.
5. Program participants meet with case manager in the housing unit a minimum of two times a month
6. Program participants will maintain receipt of supportive services and/or increase access to and receipt of additional supportive services necessary to maintain stability in housing
7. Program participants will obtain, maintain or increase household income
8. Program participants will obtain, maintain or increase receipt of mainstream benefits.

Indicators

1. The number and percentage of all program participants who remain in permanent housing, or exit to other permanent housing.
2. The number and percentage of all program participants who maintain their housing units to meet HQS requirements
3. The number and percentage of all program participants who pay their portion of the rent and the utilities that are not paid for by the landlord
4. The number and percentage of all program participants who develop and comply with case/service plan developed with case manager.
5. The number and percentage of all program participants who meet with case manager in the housing unit a minimum of two times a month

6. The number and percentage of all program participants who maintain receipt of supportive services and/or increase access to and receipt of additional supportive services necessary to maintain stability in housing
7. The number and percentage of all program participants who obtain, maintain or increase household income
8. The number and percentage of all program participants who obtain, maintain or increase receipt of mainstream benefits.

Expected Levels of Outcome Achievement

1. 90% of all program participants remain in permanent housing, or exit to other permanent housing during service year
2. 95% of all program participants will actively engage in long term case management during service year
3. 85% of program participants with income will maintain or increase household income during service year
4. 100% of program participants with zero income submit detailed plan to secure income within 60 days of program entry and provide progress reports on a quarterly basis.
5. 50% of program participants with zero income will secure and maintain household income during service year
6. 85% of all program participants will obtain, maintain or increase receipt of mainstream benefits during service year

Housing Supportive Services – Highland Commons

Program H-014

Program Purpose

Contractor will provide on-site services at the Highland Commons permanent supported housing development. These services will assist Milwaukee County Behavioral Health Division consumers with maintaining their individual housing unit and coordinate services with case management.

Required Program Inputs, Processes, and Program Activities

Services:

- Consumers are referred by CARS contracted case management agency and funded by the County.
- Consumer referrals are screened for appropriateness.
- Consumer meeting the criteria are admitted and oriented to the program.
- After orientation, a consumer signs a lease agreement, program rules sheet and develops a Wellness Recovery Action Plan (WRAP) to maintain their physical and mental health.

Professional staff works with the individual's case manager, Certified Peer Support Specialists and the resident to offer recovery-oriented services.

Certified Peer Support Specialists must complete approved training and pass the certification examination as well as complete continuing education hours (CEH) based on the program's core competencies in order to maintain his/her certification. Certified Peer Support Specialists will conduct the following groups under the supervision of professional staff:

- **Mental Health Education Groups** to offer improvements in the categories of self-stigma/insight, identifying symptoms of mental illness and coping techniques. Groups will include discussion groups, role-playing activities, reviewing media coverage (newspaper articles & mental health magazines) and educational games.

- **Groups on Medication Management to** increase understanding of medications and their importance, identify obstacles to compliance and provide/receive peer support. Groups, focusing on medication information, common side effects, interactions (nutrition, alcohol, over the counter medications, etc.) and support (peer, group, family, etc.) systems will be offered on a weekly basis.

- **Groups to create Wellness Recovery Action Plans (WRAP**) based on Mary Ellen Copeland's curriculum. Residents will demonstrate improved ability to identify personal factors that may trigger an increase in symptoms and will learn and utilize new self-care tools and strategies to prevent or reduce the severity of such incidents. All will create pre and post crisis plans.

- **Groups on community involvement**, including educational sessions on community resources, advocacy groups, landlord/tenant issues, and trainings on utilizing public transportation.

- **Groups on recovery** utilizing the Recovery Workbook created by the Boston Center for Psychiatric Rehabilitation.

- **Socialization and leisure activities** to increase psychosocial skills, including potlucks, Cooking groups, movie nights and holiday parties.

- **Functional literacy groups** to develop the necessary reading, writing and math skills to function independently.

Individual one-on-one activities with 50 residents will include:

- On-site case managements, as well as close communication with CARS case manager
- Ongoing support and direction as needed
- Assistance in establishing personal goals.
- Feedback on recovery.
- Developing independent living skills, including cleaning, meal planning and preparation, laundry, budgeting, shopping and bill paying.
- Ensuring adequate/appropriate nutrition and personal hygiene

Skill development is based on daily use of existing skills, developing new skills and learning how to problem solve

Certified Peer Support Specialists are required to have daily contact with each resident and communicate issues or concerns to other Certified Peer Support Specialists and professional staff via a computerized log. In addition, charts with medical histories and other pertinent information are kept on each resident. Staff will carry an on-call phone.

Residents will be involved in the program planning and implementation. Weekly resident meetings will be held to facilitate communication and promote needed changes.

The tentative total budget for the program is $140,000

Non-Billable Activities

Completion of annual leases and documentation for tax credits

Required Documentation

50 tenant files must be maintained according to all HUD and WHEDA standards

Annual evaluation report must be submitted to include the format and content specified in the *Purchase of Service Guidelines, Technical Requirements*

Expected Outputs

- 50 consumers will maintain their supportive housing placement
- All 50 BHD units will remain occupied
- 50 consumers will improve in accomplishing their activities of daily living (ADL)
- 50 consumers will show a decrease in mental health symptoms and relapse with substance abuse

Expected Outcomes

1. At least 80% of consumers will successfully complete a year lease at Highland Commons
2. 100% of units reserved for BHD consumers will remain occupied, allowing one month for the turnover of units
3. 70% of consumers will show an improvement in ADLs
4. 70% of consumers will show a decrease in mental health symptoms or relapse from substance abuse

Indicators

1. Percentage of consumers completing leases
2. Percentage of units occupied
3. Percentage of consumers improvement with ADLs
4. Percentage of symptom management improvement

Expected Levels of Outcome Achievement

1. At least 80% of consumers will successfully complete a year lease at Highland Commons.
2. 100% of units reserved for BHD consumers will remain occupied, allowing one month for the turnover of units.

3. 70% of consumers will show an improvement in ADLs.
4. 70% of consumers will show a decrease in mental health symptoms or relapse from substance abuse.

Keys to Independence Permanent Supportive Housing

Program H-017

Program Purpose

The purpose of the Keys to Independence Permanent Supportive Housing program is to provide consumers with housing of their choice that gives individuals the supportive services they need to locate, maintain, and be successful in their own apartments. The program also provides rental assistance funds to ensure the units are affordable.

Required Program Inputs, Processes, and Program Activities

- All consumers are referred by The Milwaukee County Special Needs Housing Division. Scattered site locations are located and funded by Milwaukee County.
- Consumer referrals are screened for appropriateness.
- Consumers meeting the criteria are admitted and oriented to the program.
- After orientation, a consumer signs a lease agreement, program rules sheet and develops a Wellness Recovery Action Plan (WRAP) to maintain their physical and mental health.
- Agency must have experience providing case management and/or supportive housing services in permanent housing. Case Managers on staff must possess a minimum of a bachelor's degree in a human services related field. All Peer Specialists must be Certified. Certified Peer Support Specialists must complete approved training and pass the certification examination as well as complete continuing education hours (CEH) based on the program's core competencies in order to maintain his/her certification. Peer Specialists must complete Certification within six months of employment.
- Professional staff will work with the individual's case manager or provide care coordination support to link consumers to community resources. Certified Peer Support Specialists provide the consumer with recovery-oriented services.
- Agencies must provide educational trainings on daily living skills including meal preparation and successfully maintaining a living environment. In addition, agency may offer educational groups and individual trainings in areas such as mental health education, medication management, creation of Wellness Recovery Action Plans (WRAP), recovery, and socialization.
- The appropriate service model will include care coordination services for those not receiving case management, collaboration with Milwaukee County BHD Service Access to Independent Living (SAIL)-contracted case managers, and the provision of certified peer specialists. These services are expected to be

performed at the consumers' residence. The agency will also master lease all units from individual landlords and will be responsible for the collection of rent from program participants.

- Staff are required to have regular and frequent contract with all program participants based on an individual's ability to maintain housing and their recovery. In addition, charts with medical histories and other pertinent information are to be kept on each resident. Staff will carry an on-call phone.
- Staff to participant ratio should be approximately 1:12.
- Unit of service is 1 hour.

The tentative total budget for the program is $400,000 of which approximately $200,000 of it is rental assistance funds.

Non-Billable Activities

Participation on various mental health and housing related committees and membership in community groups

Required Documentation

Tenant files must be maintained by the agency and shall include any contact recordings

Annual evaluation report must be submitted to include the format and content specified in the *Purchase of Service Guidelines, Technical Requirements*

Expected Outputs

- 40 consumers will maintain their supportive housing placement
- Symptom management and monitoring of daily living for optimal effectiveness and low levels of relapse
- 40 consumers' medical needs will be identified
- 40 consumers will have a completed financial profile to include a monthly budget and identification of money management skills
- 40 consumers will participate in their own treatment planning process
- 40 consumers will have a community living plan that addresses how they will maintain their housing placement

Expected Outcomes

1. At least 80% of consumers will successfully retain a year of occupancy in their respective housing placement
2. At least 80% of consumers will attain an optimal level of living skills to reduce and manage their symptoms

3. Medical issues will be incorporated in every treatment plan
4. 100% of consumers will have a financial profile indicating income and benefits along with a monthly budget
5. 80% of consumers will achieve a level of recovery that allows for a decrease in crisis services
6. 80% of consumers will retain permanent housing

Indicators

1. Percentage of consumers retaining occupancy
2. Percentage of consumers will demonstrate reduced symptoms and side effects and increased ADLs
3. Percentage of treatment plans with medical issues incorporated
4. Percentage of consumers have financial profile and budget
5. Percentage of consumers have decreased contact with PCS and/or private mental health hospitalizations
6. Percentage of consumers who retain permanent housing

Expected Levels of Outcome Achievement

1. 80% of consumers will successfully retaining a year of occupancy
2. 80% of consumers will demonstrate reduced symptoms and side effects and increased ADLs
3. 100% of consumers will have treatment plans that include medical issues
4. 100% of consumers will have a financial profile and budget
5. 80% of consumers will have a decrease in PCS and/or private mental health hospitalizations
6. 80% of consumers will successfully retain their permanent housing